

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Mental Health and/or Substance Use Disorder Treatment Records

Facility Name: Form Date:

Facility Address: Phone:

1. AUTHORIZATION TYPE (select one or more)

- Disclosure of records Inspection of records

2. PATIENT / CLIENT INFORMATION

Full Legal Name: Date of Birth:

Medical Record #: Telephone: SSN (last 4):

Address:

3. TYPE OF TREATMENT PROGRAM

- Mental Health treatment
 Substance Use Disorder treatment

4. TREATMENT DATES COVERED (REQUIRED — cannot be left blank)

From (date of first service): Through (date of last service):

- OR All dates of treatment at the facility named above

5. RELEASE INFORMATION FROM (Source) AND TO (Recipient)

FROM (releasing facility):

TO — Name of person / organization receiving records:

Recipient Address:

Recipient Email:

Recipient Phone: Recipient Fax:

6. PURPOSE OF THIS DISCLOSURE (select all that apply)

- Continuity of care / Treatment Insurance / Billing
 At patient's personal request Disability / Benefits determination
 Legal School / Employer
 Other (specify):

AUTHORIZATION FOR RELEASE OF PHI (continued)

7. SPECIFIC RECORDS AUTHORIZED FOR RELEASE

A. General records (non-sensitive):

- | | |
|--|---|
| <input type="checkbox"/> Face Sheet / Demographics | <input type="checkbox"/> Medication Administration Record (MAR) |
| <input type="checkbox"/> Admission / Discharge Summary | <input type="checkbox"/> Assessments / Evaluations |
| <input type="checkbox"/> History & Physical (H&P) | <input type="checkbox"/> Treatment Plan(s) / Reviews |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Consents / Authorizations |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> ENTIRE record (excluding sensitive items in B) |
| <input type="checkbox"/> Laboratory Results | |

B. Sensitive records — separate authorization REQUIRED for each category:

- | | |
|--|--|
| <input type="checkbox"/> Substance Use Disorder records (protected by 42 CFR Part 2) | <input type="checkbox"/> Communicable / sexually transmitted disease records |
| <input type="checkbox"/> HIV / AIDS test results, treatment, or status | |

Specific exclusions (records I do NOT authorize for release):

8. FORMAT OF DISCLOSURE (secure methods only)

- | | |
|--|--|
| <input type="checkbox"/> Paper copy (in person) | <input type="checkbox"/> Patient portal |
| <input type="checkbox"/> Encrypted email or secure file-sharing link | <input type="checkbox"/> Secure fax (with confidentiality cover sheet) |

9. PATIENT NOTICES — please read before signing

Prohibition on Re-Disclosure (42 CFR Part 2): If you have selected Substance Use Disorder records in Section 7B, this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Right to Revoke: I may revoke this authorization at any time by submitting a written revocation to the facility's Privacy Officer. Revocation will not affect any disclosures already made in reliance on this authorization.

Re-Disclosure Risk: Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization, except where permitted by law.

10. EXPIRATION OF THIS AUTHORIZATION

- | | |
|--|---|
| <input type="checkbox"/> Specific date: <input type="text"/> | <input type="checkbox"/> Upon event: <input type="text"/> |
| <input type="checkbox"/> Default — 90 days from date signed (if no other date or event is specified) | |

Maximum validity: 12 months from date signed unless otherwise required by law or by the recipient's stated need.

11. SIGNATURE — Choose ONE method (A: wet signature OR B: electronic signature)

OPTION A — WET (HANDWRITTEN) SIGNATURE

INSTRUCTIONS: A 'wet signature' is your handwritten signature in pen/ink on the paper form. To use this option: (1) print this completed form, (2) sign in the box below in blue or black ink, (3) write the date, and (4) return the original signed form (or a clearly scanned copy) to the facility.

Patient — Handwritten Signature

Date Signed (mm/dd/yyyy)

Printed Name

OPTION B — ELECTRONIC SIGNATURE (digital certificate)

By applying your digital signature below, you intend this to be your legal electronic signature, equivalent to a handwritten signature pursuant to the federal E-SIGN Act (15 U.S.C. §7001) and applicable state law (CA UETA / TX UETA). Your digital signature cryptographically binds your identity to this document.